

Table S1:

The Dizziness Handicap Inventory (DHI)

P1. Does looking up increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E2. Because of your problem, do you feel frustrated?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F3. Because of your problem, do you restrict your travel for business or recreation?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P4. Does walking down the aisle of a supermarket increase your problems?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F5. Because of your problem, do you have difficulty getting into or out of bed?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F7. Because of your problem, do you have difficulty reading?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E10. Because of your problem have you been embarrassed in front of others?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P11. Do quick movements of your head increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F12. Because of your problem, do you avoid heights?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P13. Does turning over in bed increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E15. Because of your problem, are you afraid people may think you are intoxicated?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P17. Does walking down a sidewalk increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E18. Because of your problem, is it difficult for you to concentrate	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No

Table S2:

NAME: _____

DATE: _____

VANDERBILT PEDIATRIC DIZZINESS HANDICAP INVENTORY (DHI) (Age 5-12)

Instructions: The purpose of this questionnaire is to identify difficulties that your child may be experiencing because of his or her dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question.

Answer each question as it pertains to your child's dizziness problem only.

	Yes (4)	Sometimes (2)	No (0)
1. Does your child's problem make him/her feel tired?			
2. Is your child's life ruled by his/her problem?			
3. Does your child's problem make it difficult for him/her to play?			
4. Because of his/her problem, does your child feel frustrated?			
5. Because of his/her problem, has your child been embarrassed in front of others?			
6. Because of his/her problem, is it difficult for your child to concentrate?			
7. Because of his/her problem, is your child tense?			
8. Do other people seem irritated with your child's problem?			
9. Because of his/her problem, does your child worry?			
10. Because of his/her problem, does your child feel angry?			
11. Because of his/her problem, does your child feel "down"?			
12. Because of his/her problem, does your child feel unhappy?			
13. Because of his/her problem, does your child feel different from other children?			
14. Does your child's problem significantly restrict his/her participation in social or educational activities, such as going to dinner, meeting with friends, field trips, or to parties?			
15. Because of your child's problem, is it difficult for him/her to walk around the house in the dark?			
16. Because of his/her problem, does your child have difficulty walking up stairs?			
17. Because of his/her problem, does your child have difficulty walking one or two blocks?			
18. Because of his/her problem, does your child have difficulty riding a bike or scooter?			
19. Because of his/her problem, does your child have difficulty reading or doing schoolwork?			
20. Does your child's problem make it difficult to successfully do activities that others his/her age can do?			
21. Because of his/her problem, does your child have trouble concentrating at school?			
		TOTAL SCORE	

McCaslin DL, Jacobson GP, Lambert W, English LN, Kempf AJ (2015). "The development of the vanderbilt pediatric dizziness handicap inventory for patient caregivers (DHI-PC)." *Int J Pediatr Otorhinolaryngol*. 79 (10): p1662-1666. doi: 10.1016/j.ijporl.2015.07.017

Significant change: >18 points; 0-16 no activity limitation; 16-26 mild activity limitation; 26-43 moderate activity limitation; >43 severe limitation